Client Information Sheet (Sarah Darrington -Wichita Counseling and Coaching Center)

Client:

Last Name:____ First Name:________________________________ MI_______
Street:____ City:_______________________ State:_____ Zip__________
Home Phone: ________________________ Cell Phone _________________________ SSN#_______-______-__________
Birth Date:_____________________ Age: ________ Sex: M / F Work Phone:________________________________
Email address (for adult , or parent's email address for child): ____
May we add you to our email list? (yes or no, you may unsubscribe from e-mail list at any time)____________________
Phone number you prefer for appointment reminders? (Write "None" if you want no reminders)_____________________
Education (or grade and name of school):____
Marital/relationship status:___________________________ Spouse's name____
Names and ages of all others living in the home:

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Who referred you to us?____
Who shall we contact in case of emergency?_____________________________________Phone:______________________

Responsible Party, if different from client (The person signing the fee agreement and consent for treatment):

Last Name:____________________________________ First Name:__________________________________ MI_________
Street:____ City:_________________________ State:____ Zip_________
Home Phone:_____________________ Cell Phone __________________________ SSN#________-______-___________
Birth Date:____________________ Age: _______ Sex: M / F Work Phone:____________________________
Responsible Party's relationship to client:____

Custody Information (if client is a minor, choose one or explain further):

☐ Child lives with together with both parents and the court has not been involved in custody rulings.
☐ Child's parents have joint legal custody. The other parent's name/address/phone is:

☐ Responsible party has sole custody of the child and child lives with responsible party.
☐ Legal guardian is _______________________________, child resides with _____________________________________.

Primary Insurance:

Name/Address of Insurance:____
ID#____ Group #____________________________________
Policy Holder's Name:____Date of Birth:______________________
Policy Holder's Address if different from client:____
Policy Holder's Phone number if different from client:____
Policy Holder's Social Security Number:______________________Policy Holder's Employer:______________________

Secondary Insurance:

Name/Address of Insurance:____
ID#____ Group #____________________________________
Policy Holder's Name:____Date of Birth:______________________
Policy Holder's Address if different from client:____
Policy Holder's Phone number if different from client:____
Policy Holder's Social Security Number:_________________________Policy Holder's Employer:___________________

All Clients using health insurance please sign below; parent must sign if client is under 18

I hereby grant authorization to Sarah Darrington, LMSW, to release any Protected Health Information (except Psychotherapy Notes) to my insurance company that is necessary for billing, to receive authorization for services, or to process my claim for payment of services. I authorize my insurance company to send payment directly to Sarah Darrington for all services provided. I agree that a photocopy of this authorization shall be as valid as the original.

____ ________________________
Signature (Client, or parent or guardian if client is under 18 year old) Date

Sarah Darrington, LMSW

Fee Agreement

1. **FEES FOR KEPT APPOINTMENTS:** The fee for the initial assessment will be $150.00. After that, your fee will be $120.00 per 45-50 minute session. Although health insurance may aid in payment, you alone are responsible for paying for services and appointments with Sarah Darrington, LMSW.
2. **FEES FOR MISSED APPOINTMENTS:** When you schedule an appointment with Sarah Darrington the time is reserved for you**.** There is no fee if you cancel an appointment more than 24 hours in advance of the appointment. **If you cancel or do not keep an appointment without giving twenty-four hours' advance notice, you will be charged a fee for the time you had reserved.** Insurance companies do not pay for cancelled appointments. Exceptions: 1). If you are ill and do call before the appointment time to cancel your appointment, there will be no charge. 2). If you reschedule and keep an appointment that occurs within three days of the missed appointment you will not be charged for the missed appointment.. 3.) One missed appointment fee per year will be forgiven. **All missed appointments that do not meet the exceptions above will be charged the fee of $60.00.**
3. **Telephone consultations, reports, and letters to other professionals:** May be provided as a courtesy at no fee if they are infrequent and require less than 20 minutes. Most services requiring more time, such as reports, letters, or conferences have a fee of $120 per hour.
4. **Court appearances:** Court appearances, including travel time, are $150.00 per hour. You should discuss with Sarah Darrington before sending a subpoena, because she will not often agree to appearing in court and may be expected to refuse to give a professional opinion in court. The client or parent whose attorney issues the subpoena must pay $500 in advance of a court appearance, which will be refunded if she is notified in a timely manner that the appearance is not needed.

If your insurance company requires you to get authorization from them before seeing a therapist and you do not do so, you are responsible for payment in full of the fees listed above. The final responsibility for payment is yours. This means if insurance does not provide the reimbursement expected or desired, the full balance is your responsibility.

Occasionally, Sarah Darrington may increase her standard fee. At that time, your fee will be adjusted to the new fee, this agreement will be terminated, and you will be asked to sign a new agreement which reflects the new fee.

Payment Arrangements: Accounts are payable in full within 30 days after billing unless other arrangements are made.

X STANDARD PAYMENT ARRANGEMENT: Payment for any deductible or non-insured portion of your fee is due at the time of each session.

___ ALTERNATIVE PAYMENT ARRANGEMENT:
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Collections procedures:
Sarah Darrington reserves the right to collect any unpaid balance due to her. If a client is not making regular payments on the account balance, she may use a collection agency or take legal action to secure payment, as authorized by state or federal law, and the collections action will become a part of your credit record. Clients will be notified in writing before an account is referred for collections.

I have read and understood the above fee agreement, and I agree to abide by its terms.

______________________________ ______________
Name Date
(Parent/Guardian must sign for a minor)

Consent for Treatment

Therapist Qualifications

Sarah Darrington is a Licensed Master Social Worker. She holds a Master of Social Work degree and has more than two years of social work experience. She is licensed to diagnose and treat mental disorders and to provide individual, group and family therapy with supervision. She is supervised by Susan Huebert, L.S.C.S.W., at Wichita Counseling and Coaching Center.

What to Expect from Treatment

Studies of psychotherapy indicate that most clients benefit from treatment and experience improvement in the problem areas for which services were sought. However, treatment benefits can not be guaranteed. Response to therapy is different for each client and should be discussed on an ongoing basis.

Psychotherapy can involve a variety of different activities, which vary from client to client. In general, the therapist will assess your problems and then will provide therapeutic services designed to resolve or reduce the problems. There may be individual work with you or your child, discussions with you possibly including ways to help your child outside of therapy, and/or family sessions. Therapy may focus on feelings, thoughts, relationships, and/or behaviors. With young children, therapy generally includes play activities used as a means of understanding and communicating with the child.

Assessment procedures may include standardized tests or techniques used to aid in diagnosis and treatment. Assessment for psychotherapy will not generally follow the procedures for a child custody evaluation and the therapist may refuse to give an expert opinion in court.

Confidentiality / Privacy

Historically, psychotherapy was associated with complete confidentiality between the family and clinician. Currently, both law and professional ethics require therapists to maintain complete confidentiality in the vast majority of cases. In these cases, the therapist cannot release any information about your family without your expressed permission. However, as a result of legal developments, there are some exceptional circumstances in which therapists are required to communicate information about therapy to persons outside the family. These exceptions include the following situations:

- The client presents a clear and present danger to himself or herself and refuses to accept appropriate treatment.
- The client communicates to the therapist a threat of physical violence against a clearly identified or reasonably identifiable victim, or the therapist has a reasonable basis to believe there is a clear and present danger of physical violence against such a victim.
- The client introduces his or her mental condition as a defense in a legal proceeding.
- In child custody or adoption cases, the judge determines that the therapist has information bearing significantly on the client's ability to provide suitable care.
- The client initiates legal action against the therapist.
- The therapist has grounds to believe a child under the age of 18 or an elderly person (over age 60), or a handicapped adult, has been, or is at risk of being abused or neglected.
- The therapist has reason to believe a health care professional has engaged in professional misconduct.
- A judge orders the therapist to release client information.

It should also be noted that insurance companies reimbursing mental health services require information about these services. Therefore, if you are using insurance to pay for the treatment, information will be released to your insurer.

Any matter brought to the therapist's attention by a child or either parent regarding the child may usually be revealed to either or both parents. Matters that are irrelevant to the child's welfare may be kept in confidence. The decision whether to disclose relevant information is a matter of the therapist's professional judgment.

Please refer to the "Notice of Privacy Practices" Handout for additional information about compliance with HIPAA law relating to privacy and our practices. Sarah Darrington is an independent practitioner who has business associates agreements, (contractual agreements in order to insure confidentiality,) in place with Wichita Counseling and Coaching Center. Wichita Counseling and Coaching Center files insurance claims and schedules appointments and provides therapists she may consult with to improve patient care or to cover for her when she is on vacation. She regularly may consult with the affiliated therapists at Wichita Counseling and Coaching Center regarding best practices in patient care.

If you do not consent for Sarah Darrington, LMSW to consult with the other affiliated therapists at Wichita Counseling or Coaching Center, or other licensed mental health professionals contractually bound to maintain your confidentiality while assisting her, please check and initial here. ______

Mail, Email or Phone Contact From Wichita Counseling and Coaching Center:
As a part of our ongoing healthcare operations, on an infrequent basis we may sometimes send our clients and former clients' information about our services such as a newsletter, or birthday or Christmas greetings, either by mail or email. If you prefer that we do not put you on our mailing list or contact you regarding anything except your current treatment, billing or insurance, please initial here. ______

Our assistant generally calls one or two days before appointments with appointment reminders and may leave a message if you have an answering system. If you have special instructions regarding communications such as where to send bills, how or when to contact you, or what kind of message we may leave at home or elsewhere, please tell us here (otherwise we will use our standard procedures and information you provided on the client information sheet):

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I, ______________________________________, for myself and/or as parent or legal guardian of ____________________________________, indicate by my signature on this form that I consent to the evaluation/treatment process with Sarah Darrington, L.M.S.W. I understand that this process may include myself, my child, and/or other family members. I understand and consent to the conditions described above. I also acknowledge that I have received the Notice of Privacy Practices on the following pages and have been informed of the exceptions to confidentiality as described above.

Signature: _______________________________ Date: _________

Sarah Darrington, L.M.S.W. Notice of Privacy Practices
Patient Summary

I understand that health information about you is personal. I am committed to protecting your personal health information and privacy.

I will use your information to provide you care and treatment, create a record of the care and services you receive, bill your insurance in a timely fashion and operate the office in a diligent manner.

I will safeguard your information and share it only with those who need or are entitled to know. I will obtain your permission for other use or disclosure.

You may ask to see, change, restrict or obtain a copy of your information and file a formal complaint if I fail to assure your privacy or information confidentiality.

For more details, please read this Notice of Privacy Practices.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions, please contact the office at
(316) 729-9965

These Privacy Practices guide the practice of Sarah Darrington, L.M.S.W., including any staff I may hire or any business associate or treatment professional with whom I need to share your health information.

We are required by law to:

- **Keep health information about you private.**
- **Provide you this notice of our legal duties and privacy practices with respect to health information about you.**
- **Follow the most stringent state or federal law.**
- **Abide by our currently published Notice of Privacy Practices.**

We may change our policies at any time. Changes will apply to health information we already have. You will be notified if we make significant changes to our policy while you are receiving our services. You will be offered a copy of the current notice at the time you are admitted for treatment. You will also be asked to acknowledge in writing your receipt of this notice.

How we may use and disclose health information about you.

- **We may use and disclose health information about you for** treatment **(example, sending medical information about you to a specialist as part of a referral);** to obtain payment for treatment **(example, sending billing information to your insurance company); and** to support our health care operations **(using patient information to improve quality care).**
- **We may use and disclose health information about you** without **your prior authorization for several other reasons. Subject to certain requirements, we may give out health information about you without prior authorization for** public health purposes, abuse or neglect reporting, health oversight audits or inspections, funeral arrangements, organ donation, workers' compensation purposes, and emergencies. **We also disclose medical information when required by law, such as in response to** valid judicial **or** administrative orders**.**
- **We may disclose health information about you to a friend or family member who is involved in your medical care or to disaster relief authorities so that your family can be notified of your location and condition.**

Other uses of health information.

- **In any other situation not involving routine care, financial and insurance matters or office operations, we will ask for your written authorization before using or disclosing health information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.**

Your rights regarding health information about you.

- **In many cases, you have the right to look at or get a copy of health information that we use to make decisions about your care, after you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.**
- **If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us;**
  if it is not part of the health information maintained by us; or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record.
- **You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.**
- **If this notice was sent to you electronically, you have the right to a paper copy of this notice.**
- **You have the right to request that health information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.**
- **You may request, in writing, that we not use or disclose health information about you for treatment, payment or health care operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision on your request.**

  All written requests or appeals should be submitted to our Privacy Office listed at the bottom of this notice.

Complaints

- **If you wish to file a complaint because you feel that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Office (listed below).**
- **Finally, you may send a written complaint to the U.S Department of Health and Human Services Office of Civil Rights.**
- **Under no circumstance will you be penalized or retaliated against for filing a complaint**

Sarah Darrington, L.M.S.W., Privacy Officer
(316) 729-9965
520 S. Holland Ste. 401
Wichita, Ks 67209

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201

Effective: September 29, 2009.

RELEASE OF INFORMATION TO PHYSICIAN
OR
WAIVER OF PHYSICIAN CONSULT

I under stand that my records are protected under the applicable state law governing confidentiality of client/therapist relationship and cannot be disclosed without my written consent unless otherwise provided for in state of federal regulations. I also understand that I may revoke the consent at any time except to the extent that action has been taken in reliance on it.

In accordance with K.SA. 65-63O6, when a client has symptoms of a mental disorder, a licensed master social worker (LMSW) shall consult with the client's primary care physician or psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to the clients symptoms of a mental disorder, A client may request in writing that such consultation be waived and such request be made part of the client's record.

I, hereby authorize Sarah Darrington, L.M.S.W. to act on the following:

Please check one:

_____I consent to reciprocal release of information to my physician

_____I do NOT consent to reciprocal release of information to my physician and waive the physician consult.

____
(Client's Printed Name)

____ _______________
(Client's Signature or Parent/Guardian Signature) (Date)

____
(Parent/Guardian's printed name and relationship)

Physician's Name, Address, and Phone Number:

____

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